Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

A. BUILDING 01 - MAIN BUILDING 01

B. WING _______

12/20/2010

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NHC HEALTHCARE, OAK RIDGE

300 LABORATORY RD OAK RIDGE, TN 37831

HC HEALTHCARE, OAK RIDGE	OAK RID	GE, TN 378	31
(X4) ID SUMMARY STATEMENT OF DEFICI PREFIX (EACH DEFICIENCY MUST BE PRECEDI TAG REGULATORY OR LSC IDENTIFYING INF	ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
N1411 1200-8-614(2)(a)5.(iii) Disaster Pr (2) Physical Facility and Communit Plans. (a) Physical Facility (Internal Situations. 5. Each of the following disaster proplans shall be conducted annually promoth listed in the plan. Drills are in purpose of educating staff, resourced determination, testing personnel satisfied and communications with other factorial community agencies. Records whith and evaluate these drills must be mat least three (3) years. (iii) Bomb Threat Procedures Plantexercised at any time during the year (I) Staff duties by department and passignment; and, (II) Search team, searching the present the present of the process of the process of the process of the process of the present the present the present of the present the present of the present the	tions). reparedness prior to the for the enfety provisions illities and ch document maintained for to be ar: job emises. by: ew, the facility was exercised the record enders and the record enders a	N1411	1. Bomb threat drill was conducted on 12-29-10. 2. Bomb threat and other drills will be monitored dor correct date. 3. Maintenance director will ensure that drills are held in a timely manner. 4. Maintenance director will monitor bomb threat drills for correct time frame. 12-29-

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Am TITLE

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STATE FORM

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6SR221

If continuation sheet 1 of 1